

USE OF CAM IN LOCAL AFRICAN-AMERICAN COMMUNITIES: COMMUNITY-PARTNERED RESEARCH

Marina C. Barnett, DSW; Margaret Cotroneo, RN, PhD; Joseph Purnell;
Danielle Martin, MHS; Elizabeth Mackenzie, PhD; and Alfred Fishman, MD
Philadelphia, Pennsylvania

Although previous national surveys have shown an increase in the use of complementary and alternative medicine (CAM) in the U.S. population, racial and ethnic minority populations were under-represented in these surveys. As a result, a profile of the CAM user as white, female, affluent, middle-aged and well educated has emerged. Representing the mainstream population, these previous studies did not take into account the racial and ethnic minority populations who may have their own healing traditions and who may hold different beliefs, use different terminology, and have unique patterns of CAM use. In partnership with community-based organizations and community residents, a culturally sensitive survey instrument and protocols were designed and tested to gather data on lower income, urban African-Americans' use of, attitudes toward, and understanding of CAM. The major findings of this pilot research are 1.) Community-partnered research can help researchers gain access to sensitive data and design culturally appropriate studies; 2.) CAM terminology varies by cultural group; 3.) Certain forms of CAM (folk or family practices) are commonly found in African-American populations; and 4.) Factors that affect CAM use—including age, lack of access to conventional medicine, cultural heritage, and dissatisfaction with conventional medicine. (*J Natl Med Assoc.* 2003;95:943–950.)

Key words: African American ♦ black ♦ CAM
♦ home remedies

Background and Significance

Complementary and alternative medicine (CAM) includes a broad range of healing philosophies and

therapies that are currently not integrated with conventional medicine and are not widely taught in western medical schools or available in most mainstream health care settings¹. One national survey reported that CAM use in the U.S. between 1991 and 1997 increased from 32.8% to 42.1%². Herbs and high-dose vitamins are the major contributors to this increase². Sales of dietary supplements alone now exceed \$200 million/year³. This rise in CAM use has had broad consequences in both the economic communities and the conventional medical communities. Responding to employee and employer pressures, over 65% of HMOs now offer at least one type of CAM coverage⁴. The increasing popularity of CAM and the resistance to many forms of CAM by the established medical community have spurred research interest in their efficacies and their useful integration with conventional therapies.

© 2003. From the School of Social Administration, Temple University of Pennsylvania (Barnett); Family and Community Health, University of Pennsylvania School of Nursing (Cotroneo); Neighborhood United Against Drugs (Purnell); Southwest Community Services (Martin); Division of Geriatric Medicine, University of Pennsylvania Health System (Mackenzie); and University of Pennsylvania School of Medicine (Fishman). Send correspondence and reprint requests for *J Natl Med Assoc.* 2003;95:943–950 to: Marina C. Barnett, DSW, Undergraduate Program Chair, Temple University School of Social Administration, 529 Ritter Hall Annex, 1301 Cecil B. Moore, Philadelphia, PA 19122; phone: (215) 204-1228; fax: (215) 204-0554; e-mail: mbarnett@astro.temple.edu

Several national studies of CAM use have been conducted in the general population. However, few, if any, over-sampled ethnic minority populations^{2,5,6}. The profile they generated of the typical CAM user (middle class, educated, more affluent, white female) may not be an accurate picture of CAM use among ethnic minorities who may have different beliefs, terminology, use patterns, and responses to CAM⁷. In particular, African-American populations have a long-standing tradition of CAM use (home remedies, root working) that is not fully assessed in existing surveys⁸. Surveys of CAM use among this population in this last decade have generally been small and limited to specific groups⁹⁻¹². A study conducted by Mackenzie et al.¹³, found that CAM use did not differ by ethnicity; this study used a national probability sample (n=3,789) with an over-sampling of ethnic minorities.

African Americans and CAM Use

Based upon the literature, CAM use among African Americans tends to differ depending upon location and age of the respondents. Much of what is known about CAM use among African Americans is drawn from studies of their folk medical practices, such as home remedies, family remedies, and root working. These terms are closely related to African-American folk healing traditions of the rural and urban poor^{8,14-16}. During centuries of oppression and poverty, African Americans were often isolated from even rudimentary medical care and therefore developed their own healing traditions using easily accessible herbs, foodstuffs, and other substances.

These beliefs remain a strong force in the African-American community today and are reflected in the health care-seeking behaviors that emphasize control over one's experiences and self-care¹⁷⁻¹⁹. Their self-care practices have been linked to economic sufficiency, social pride, and accountability^{20,21}. Bailey has proposed a simple definition of African-American alternative medicine that summarizes key findings in the literature: "African-American alternative medicine consists of believing in and/or using 'natural' and/or 'supernatural' treatment therapies that will significantly contribute to the healing process within a holistic, familial, and socioeconomic setting."²²

Age is an important factor with respect to the use of CAM by African Americans^{8,10,11}. Prior to 1980, the typical African-American CAM user was

defined as a female who lived with grandparents in rural southern U.S., whose father had little education, and who had a strong religious background⁸. In a recent study of a group of African-American women living in a large northeastern city, older women held more positive views and used CAM more frequently than did younger women¹⁰. A study of elderly African-American women living in community housing found that 80% used folk or family remedies, such as wild cherry bark tea, onion soup, musterole applied to the chest, garlic, and cayenne pepper routinely to manage colds, pain, catharsis, and hypertension¹¹.

In contrast, a recent small study of middle-class African-American mothers caring for children with common colds found that their CAM practices were very similar in frequency and type to those of caucasian mothers¹². The younger African Americans, with greater access to education and to the Internet—with its information on health and illness—may well be in step with that segment of the mainstream population who are using a broader range of CAM as a means of maintaining their health.

While the practice of using traditional or folk remedies may be declining in younger African Americans, other cultural beliefs endure that impact African-American health perceptions and seeking of medical care^{9,23,19}. An attitude of mistrust of the health care system, a system dominated by European Americans largely from the upper and upper middle class, continues according to anecdotal reports in several studies^{9,15,19,22}. This mistrust, which has its origins in U.S. history, has serious consequences for both the patient and the health care provider, as it forms a barrier to easy and full communication. Use of CAM is a window to these belief systems and a salient factor in developing therapeutic plans^{17,20,26}.

A second factor impacting the use of CAM is the expense of conventional medical care. African Americans make up 20.6% of the medically uninsured²⁵. As a consequence, they will often delay seeking medical care until a health need is acute. Mackenzie et al.¹³ found that being uninsured, regardless of ethnicity, was a predictor of CAM use. Closely intertwined with health beliefs, the use of self-care practices (home remedies and family remedies) is a key cultural factor in the health care utilization patterns of African Americans that merits closer attention^{8-10,19,23}.

Table 1. Participant Demographics (N=51)

Gender	39% Male (n=20) 61% Female (n=31)
Age*	8% <30 years (n=4) 29% 31–45 years (n=15) 45% 46–65 years (n=23) 18% > 65 years (n=9)
Race	84% African American (n=43) 16% Black/Non-African-American (n=8)
Birthplace*	55% Philadelphia and suburbs (n=43) 20% Southern states (n=10) 8% Other/U.S. (n=4) 6% Other/international (n=3)

* Indicates missing records

In comparing recent studies of African-American and CAM use, what is becoming clear is that there is no single profile that fits all African-American CAM users. Rather, the study population has to be well defined, and the data collection methods should address aspects of CAM use specific to the study population and should include not only cultural factors but also social and economic factors that underlie their use. This study reports the use of focus groups composed of lower-income, urban African Americans to identify content for a culturally sensitive semi-structured interview to assess CAM use among this population and reports the profile generated from a pilot study employing the technique.

Community-Partnered Research

National surveys of CAM use have used different methods to determine prevalence, including telephone^{2,3,4}, mail⁶, and secondary analyses of national data sets^{8,13,26,27}. The surveys have a set form that lead in a certain direction and tend to use categories of CAM that are broadly recognizable by the dominant culture or CAM practices more easily linked to medical settings as opposed to self-care²⁸.

These national surveys target a general population and are less appropriate for studies of CAM use by African Americans. On the other hand, studies of African Americans in medical settings have usually been conducted in specialty clinics, among patients with specific diseases, or in unique populations³¹. Patients in these settings may be less candid in discussing self-care practices with the result that CAM

use gets under-reported. Clinical samples also miss those who underutilize biomedical services.

Another way to elicit information from under-represented groups about sensitive subjects is to use focused group interviews. This is a form of participatory action research (PAR) using consensus-sampling methods. A facilitator guides a small group of persons who share some common characteristics through an in-depth discussion of selected issues²³. This is an effective method for eliciting culture-specific beliefs and values about health, particularly in under-represented populations.

Increasingly, community-based or community-partnered research is being recognized as an essential element of reducing racial and ethnic disparities in health-related outcomes^{30,31}. A community-based research approach is population focused. Its aim is to understand the broader social/environmental context of health behaviors and risks. The partnership extends to all phases of the research process and allows a built-in mechanism for dissemination of research findings.

For this pilot study, we drew our sample from a lower income, predominately African-American community in southwest Philadelphia with whom we have worked for several years. The participants came from the same community that has had a role in the development of the tools we used. The participants met in the community in small groups led by individuals who were also residents of the community.

Based on our experience collecting pilot data, community-partnered research has the potential to help researchers gather previously inaccessible data, while improving community-academic relations.

METHODS

This study used qualitative methods, employing in-depth semi-structured focused group interviews with 51 participants in six focus groups to explore African American's use of and attitudes toward complementary and alternative medicine (CAM) and to assist in the development of an interview guide and protocol for further study. The sample selection was non-random. The participants were recruited with the help of three community-based organizations who drew upon their membership and associates to volunteer to participate. These community-based organizations primarily serve lower-income African Americans from west and southwest Philadelphia. Each participant was paid \$25 for the two-hour session.

Table 2. Examples of CAM Use

Condition	Treatment
Colds	Cod oil and sugar, onions and honey, lemon tea and honey, castor oil, chicken soup, Father John, 666, Rock & Rye, hot toddy, sassafras tea
Fever	Wrap pickles, slices of potatoes, or onions in a sock and wrap around hands or bottom of the feet; clove of garlic around the neck, spirits of ammonia or cider diluted with water
Mumps	Sardine sauce in sock around face and throat
Cuts	Cob webs, brown paper bag, soot from the chimney, tobacco, tobacco spit, red clay mixed with vinegar, pour alcohol (whiskey) or Coke on it, aloe vera, fatback, salt water, and sugar
Burns	Butter/cooking grease/cocoa butter, aloe vera plant, turpentine, and boiled ginseng weed
Serious/Chronic Illness	
Cancer	Marijuana, prayer, diet high in white starch and vegetables, fruit, and juice from greens
High blood pressure	Garlic or vinegar
Diabetes	Healthy diet, cayenne pepper and garlic, orange juice
Clean system/ unclog arteries	Garlic, enema, cayenne pepper, castor oil, Golden Seal, echinacea, cranberry juice, and apple juice
Other Conditions	
Ring worm	A penny soaked in vinegar and rubbed over ring worm
Boils	Rub potato or the film from the inside of an eggshell on it
Digestion	Parsley and cayenne
Gas	Vinegar and baking soda

Significant effort was made to ensure that the sample was diverse with regards to gender, age, and geographic origin. To ensure this diversity, the organizers convened two focus groups that were gender specific (all male or all female), one age-specific group (all seniors over the age of 60, held at nursing homes), and five groups that were of mixed ethnic background, gender, and age and employment status. The only criteria for selection was that the person live in west or southwest Philadelphia and self-identify as African American. All focus groups were held within the targeted community to facilitate travel convenience for the participants and were led by the same two facilitators, who were also residents of the community. Table 1 details the demographic description of the sample.

Signed consent was given by the participants to

tape the focus group responses. Standard research protocols were followed to ensure confidentiality of the participants. The questions that follow are the standard questions that were asked of all of the respondents. Questionnaire categories were selected on the basis of literature suggesting they may have particular relevance to CAM use in our population. Due to the nature of group interviews, it was often necessary to follow up with additional questions. The semi-structured interview guide questions included:

1. Personal and background information—Age, ethnic background, current residence, place of birth

2. Knowledge of CAM—What does the term “complementary and alternative medicine” mean

to you? Are you aware of the types of CAM? Where did you learn about this?

3. Use of CAM—Have you or any of your family members used CAM? What remedies do you use? When are you most likely to use these remedies? Under what conditions do you favor “conventional medicine” over the use of CAM?

4. Conventional medicine and CAM use—Does your doctor use or recommend the use of CAM? Do you inform your doctor of your use of CAM? What is his/her reaction?

5. Presentation of the survey instrument and research protocol—Each survey question was read aloud to the group, and members were asked for their responses to the questions. They were then asked specifically for their reactions to the instrument and protocols. What are your impressions? What worked and what didn't? How would you improve upon the survey? What is the best method for collecting information about CAM use among African Americans?

After the focus group discussion, the questionnaire was demonstrated on a volunteer in front of the group. The focus group participants commented on the structure, format, content, appropriateness, and ordering of the instrument items.

All group responses were transcribed, coded and verified twice to ensure accuracy of the responses. Content analysis was performed on the information gathered in the structured interviews to count the use of specific phrases or terminology and to aid in the development of theories, and identifying universals and dissimilarities in the responses.

Focus Group Findings

Knowledge of CAM. Although most respondents were not familiar with the term CAM, they indicated, upon dissecting the words, that it meant “alternative medicine”, “holistic”, and “old-fashioned ways of healing”. Many participants felt they better understood terms, such as “home remedy”, “natural”, or “healing,” as opposed to “CAM”. In all cases, participants agreed that these “tried and true” methods of relieving ailments were home remedies that were handed down from grandparents to the present generations. In most cases, it was acknowledged that these remedies were used primarily because of the lack of access to adequate health care available to their elders. It was reported that in “those days” the doctors were either too

expensive or too far away to be of use to the families. “It was all we had,” remarked one member of the men's focus group in response to the question.

Use of CAM. Analysis of our focus groups revealed that CAM use was most common in women and men over the age of 40. Responses have been summarized in Table 2.

In addition to the home remedies listed above, participants were also asked to respond to their knowledge of and frequency of use of other types of CAM. Of the 15 types of CAM therapies listed (acupuncture, biofeedback, chiropractic, energy medicine, exercise/movement, herbal medicine, homeopathy, hypnosis, massage, nutritional supplements, vitamins, relaxation techniques, special diets, spiritual or religious healing/prayer, traditional Chinese or Indian medicine),^{2,6} respondents indicated that they were most likely to use vitamin supplements and special diets. Hypnosis, acupuncture, and biofeedback were the least used.

Participants, in particular those over the age of 60, indicated that they would use home remedies first for a minor illness, such as cold, cut, or burn. Respondents said they would go to the doctor for a serious illness, such as high blood pressure or diabetes, but would use alternative medicine with a life-threatening condition (e.g., cancer), if conventional medicine had negative side effects. It is important to note that the men surveyed were more likely to self-treat first and then go to a doctor if the condition worsened. Respondents also indicated that if the prescribed medication were too expensive, they would consider cheaper, alternative methods.

Although elderly participants said they still use these remedies and pass them on to their children, most said they don't use remedies anymore, “because the earth is too contaminated and remedies are no longer pure”. In the past, “the soil was pure, we grew and cooked our own food”. Participants indicated that an over-reliance on processed and fast foods, the contamination of the soil, lakes, and streams impacted their ability to find “pure” ingredients. An example is the use of sassafras tea. The participants did not feel that the processed teas on the market could compare with the sassafras that their grandparents would “pick” to make tea. (It is necessary to report that all of the members of the seniors group were residents of a residential nursing facility where they received daily medical care and would not have access to ingredients necessary for the alternative or home remedies).

In the oldest category of respondents, although all members grew up using CAM or "home remedies", the women participants reported that now that they have medical insurance, they are more likely to go to the doctor than to use home remedies. Those respondents who used both remedies and conventional medicine reported that they do not inform their doctors of their use of alternative medicine or therapies and felt that their doctors would not approve of their use of these approaches. The decision of whether to inform the doctor about the use of these remedies was influenced by the age and race of the doctor. Participants indicated that older doctors who were either black or Asian were more likely to be accepting of these remedies. It must be noted, however, that participants did not feel that race and/or age of the doctor impacted their decision to use alternative medicine.

Participants who were ≥ 40 years old were most likely to report both knowledge and current use of family/home remedies. These "tried and true" remedies had been taught to them by their parents, and they, in turn, had used these remedies on their children. The most widely used remedies were those for colds, minor cuts, burns, and bruises. There was an emphasis on holistic living among the participants in this age group. This group was most likely to report the use of "home remedies" rather than using over-the-counter medications or other "conventional" medical practices: "I eat an orange every night before I go to bed to aid in digestion and to prevent constipation", reported one participant. Other practices included rubbing olive oil on the face to maintain a clear complexion, regularly scheduled colonics, and maintaining a good diet and exercise regimen. Although these participants referred to these practices as "home remedies", they are also embraced by mainstream medicine. This age group also reported the highest usage of CAM for chronic illnesses, such as cancer. Participants reported turning to their local herbal supplement merchant for suggestions when side-effects from prescribed medications became too overwhelming.

It is important to note the psychological effect that using various home remedies had on the respondents. Overall, participants who used CAM felt that the use of remedies or CAM enabled them to be more in control of their health. These participants reported that they felt empowered by their ability to manage their own health care. This is par-

ticularly true if the medication prescribed by a doctor caused side-effects.

The youngest category of participants, those less than 30 years old, was the least likely to report the use of CAM. As one participant remarked, "There is not the communication with the kids these days like there used to be". Another participant reported, "kids these days aren't into alternative medicine". The youngest group of participants was most likely to report that they used prevention methods, such as moderating their diet and exercise. Although these participants remembered the home remedies employed by their parents, they were more likely to use over-the-counter medicine or to go to a doctor.

DISCUSSION

The study found extensive use of CAM in this community if the definition is expanded to include home remedies/family remedies. All participants identified some form of CAM use. The user profile that emerged is summarized as follows: CAM use is:

- passed from generation to generation from grandparents, parents, and elders;
- used primarily because of a lack of access to medical doctors (financial or distance);
- most common among women and men >40 years old;
- less common among those <30 years old (who are more likely to use prevention methods, such as moderating diet and exercise);
- not disclosed to doctors during routine visits.

With respect to the survey instrument itself, the responses of the focus groups recommended collecting data in a "natural" social group context as opposed to telephone or door to door. In addition, the respondents recommended shortening the length of the questionnaire to include only the most pertinent questions, eliminating questions about medical diagnoses because they are "too personal"; replacing unfamiliar terms with familiar words and phrases; and using more open-ended questions so that respondents have an opportunity to give examples. We found this social aspect of data collection to be particularly important to gaining cooperation and trust in our population of lower-income, urban African Americans. Respondents also recommended filling out the questionnaire first and then engaging in a discussion about the responses.

Using the comments from the six focus groups,

the instrument and protocol were revised and tested for feasibility in two additional focus groups (N=21), finding them sensitive and appropriate. The revised instrument (Health Behaviors and CAM Use Questionnaire) included questions on participants' sociodemographics, health-seeking activities, use of CAM, provider relationships and general questions on health and functioning. Completion time for the questionnaire was 20 minutes, followed by a 60-minute discussion of the responses.

Our approach, community-partnered research, was one that involved extensive collaboration among faculty from two major Philadelphia universities and leaders from three community-based organizations. This collaboration fostered mutual respect among various planning participants and resulted in the utilization of a community-centered and driven approach.

Based on our experience collecting pilot data, community-partnered research has the potential to help researchers gather previously inaccessible data, while improving academic-community relations. By providing subjects in the community with a place at the research table and a tangible return for their participation, investigators began to erode the long-held perception that research is more for the benefit of the academic investigators than for the benefit of the communities involved in the study.

In community-partnered research, the investigators must be sufficiently open to consider community perspectives and flexible to implement their recommendations. Perhaps the most crucial piece of establishing community-partnered research is making sure that the community's goal for the research is met. Based on our pilot data, examples of worthwhile products from researching CAM use among African-American groups would be data that educated the community about CAM, informed physician education programs, and facilitated the formation of culturally competent systems of care.

The researchers were able to meet in familiar settings with participants and conduct conversations on the best manner by which to collect information on this subject. Ultimately, the respondents indicated that they would be most likely to respond to an interview, such as this one, in a more familiar setting. Many expressed a preference for a group setting where they could discuss the issue with others face to face, rather than simply filling out a

questionnaire. As one participant responded, "I am really enjoying this. This is the first time that I can think of when I have sat down with a group of women to discuss a topic like this." In doing so, participants felt not only that they were able to share their own experiences but also to learn from others.

With respect to African Americans, studies using subjects recruited with a community-partnered research approach and employing context-sensitive methods that are designed to capture the group's health beliefs and self-care practices are likely to provide data that has previously been inaccessible.

CONCLUSION

CAM use is multidimensional. Its integration into the conventional medical community will have to include the study of ethnomedical practices with context-sensitive studies designed to capture these practices on the ethnic group's own terms. A patient's ethnomedical practices influences their relationship with the health care provider and the health care delivery system. Using culturally sensitive methods and instruments to ask about CAM use will complement existing national surveys by overcoming biases inherent in telephone survey methods. Identifying the patterns of CAM use within a defined ethnic population can provide the basis for the design of clinical trials and intervention studies to test the effectiveness of selected treatments, using methods that are faithful to the actual health practices of the subjects³¹. Furthermore, studies of this nature can facilitate the integration of self-care practices into conventional health care and can inform studies of patient decision-making in the treatment of chronic illnesses, like hypertension²². Finally, community-partnered research has the potential to powerfully influence current efforts to create culturally competent systems of care, thereby assisting in redressing ethnic and racial health disparities.

ACKNOWLEDGEMENT

This pilot study was supported by the small grants programs of the Office of Program Development, University of Pennsylvania School of Medicine and the Center for Nursing Research, University of Pennsylvania School of Nursing. The authors acknowledge the consultation of David J. Hufford, PhD and Ellen Fuller, PhD in the development of this study.

REFERENCES

1. National Center for Complementary and Alternative Medicine. (2001). Expanding horizons of healthcare. Five-year strategic plan 2001–2005. Available at <http://nccam.nih.gov/strategic>. Accessed May 25, 2001.
2. Eisenberg DM, Davis RB, Ettner SL, Appel S, Wilkey S, Van Rompay M, Kessler RC. Trends in alternative medicine use in the United States: 1990–1997: Results of a follow-up national survey. *JAMA*. 1998;280:1569-75.
3. Blendon RJ, DesRoches CM, Benson JM, Brodie M, Altman DE. Americans' views on the use and regulation of dietary supplements. *Arch Internal Med*. 2001;161:805-810.
4. Landmark Healthcare, Inc. (1999). The Landmark Report II on HMOs and Alternative Care. CA: Landmark Healthcare, Inc. Available at <http://www.landmarkhealthcare.com>. Accessed August 7, 2000.
5. Eisenberg DM, Kessler RC, Foster C, Norlock FE, Calkins DR, Delbanco TL. Unconventional medicine in the United States: prevalence, costs, and patterns of use. *NEJM*. 1993;328:246-52.
6. Astin JA. Why Patients Use Alternative Medicine: Results of a National Study. *JAMA*. 1998;279:1548-1553.
7. Wootton JC, Sparber A. Surveys of complementary and alternative medicine: Part I general trends and demographic groups. *J Alt Comp Med*. 2001;7:195-208.
8. Boyd EL, Taylor SD, Shimp LA, Semler CR. An assessment of home remedy use by African Americans. *J Natl Med Assoc*. [Electronic version] 2000;92:341-353.
9. Fletcher AB. African-American folk medicine: A form of alternative therapy. *ABNF Journal*. 2000;11:18-20.
10. Cushman LF, Wade C, Factor-Litvak P, Kronenberg F, Firester L. Use of complementary and alternative medicine among African-American and Hispanic women in New York City: a pilot study. *J Amer Med Women Assoc*. 1999;54:193-95.
11. Fahie VP. Utilization of folk/family remedies by community-residing African-American elders. *J Cultural Diversity*. 1998; 5:19-22.
12. Patcher LM, Summer T, Fontan A, Sneed M, Bernstein BA. Home-based therapies for common cold among European Americans and ethnic minority families: the interface between alternative/comparative and folk medicine. *Arch Peds*. 1998; 152:1083-1088.
13. Mackenzie E, Bloom B, Hufford D, Johnson C. Ethnic Minority Use of Complementary and Alternative Medicine (CAM): A National Probability Sample of CAM Users. *Alternative Therapies in Health and Medicine*. Accepted for publication (2002).
14. Mathews, HF. Rootwork: Description of an ethnomedical system in the American South. *Southern Med J*. 1987;80:885-91.
15. Snow LF. Traditional health beliefs and practices among lower class Black Americans. *The Western J Med*. 1983;139:820-8.
16. Ness RC, Weintrob RM. Folk healing: a description and synthesis. *Amer J Psychiatry*. 1981;138:1477-1481.
17. Flores G. Culture and the patient-physician relationship: achieving cultural competency in health care. *J Peds*. 2000;136:14-23.
18. Fishman BM, Bobo L, Kosub K, Womedodu J. Cultural issues in serving minority populations: Emphasis on Mexican Americans and African Americans. *Amer J Med Sci*. 1993;306: 160-166.
19. Bailey EJ. Sociocultural factors and health care-seeking behavior among black Americans. *J Nat Med Assoc*. 1987;79:389-92.
20. Heurtin-Roberts S, Reisin E. The relation of culturally influenced lay models of hypertension to compliance with treatment. *Amer J Hypertension*. 1992;5:787-92.
21. Boutain DM. Discourses of worry, stress, and high blood pressure in rural south Louisiana. *J Nursing Scholarship*. 2001; 33:225-230.
22. Bailey E. African-American Alternative Medicine: Using Alternative Medicine to Prevent and Control Chronic Diseases. Westport, Connecticut: Bergin & Garvey; 2002.
23. Airhihenbuwa CO, Kumanyika S, Agurs TD, & Lowe A, Saunders D, Morssink CB. Cultural aspects of African American eating patterns. *Ethnicity and Health*, 1. 1996;1:245-260.
24. Brown CM, Segal R. The effects of health and treatment perceptions on the use of prescribed medication and home remedies among African-American and white American hypertensives. *Social Science Medicine*. 1996;43:903-917.
25. Addressing Racial and Ethnic Disparities in Health Care. Fact Sheet, February 2000. AHRQ Publication No. 00-PO41. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research/disparit.htm>.
26. Paramore LC. Use of alternative therapies: estimates from the 1994 Robert Wood Johnson Foundation National Access to Care Survey. *J Pain Symptom Mgmt*. 1997;13:83-89.
27. Bausell RB, Lee W, Berman BM. Demographic and health-related correlates of visits to complementary and alternative medical providers. *Medical Care*. 2001;39:190-196.
28. Hufford DJ. Folk medicine and health culture in contemporary society. *Complementary and Alternative Therapies in Primary Care*. 1997;24:723-41.
29. Boutin PD, Buchwald D, Robinson L, Collier AC. *J Alt Com Med*. 2000;6:335-343.
30. Sullivan M, Kelly JG, eds. Collaborative research. University and Community Partnership. Washington, DC: American Public Health Association; 2001.
31. Balick MJ, Lee R. Looking within: Urban ethnomedicine and ethnobotany. *Alternative Therapies*. 2001;7:114-15.

We Welcome Your Comments

The *Journal of the National Medical Association* welcomes your Letters to the Editor about articles that appear in the JNMA or issues relevant to minority health care.

Address correspondence to ktaylor@nmanet.org.